MEDICAID PAYMENT ALERT

TO: CLAIMS AUDITOR
CLAIMS PROCESSING
MEDICAL SERVICES
600 E BOULEVARD DEPT 325
BISMARCK ND 58505

FROM:(Provider Name and Address)

NAME	MEDICAID ID NUMBER	BIRTH DATE	PROVIDER NUMBER	ADMISSION DATE	STATE OFFICE USE

Signature: **Date of Report:**

Note: This form must be submitted on all new Medicaid recipients and recipients who apply for Medicaid after review is completed by Dual Diagnosis Management.